STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	C 03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	**234 MANOR CIRCLE ALMA, KS 66401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #84380, 84385, 84391, 84394, and 84411.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. Based on observation, interview, and record review the facility failed to notify resident #1 ' s physician as ordered with weight gains and losses.

Findings included:

- The facility admitted resident #1 on 5/20/14 with the diagnosis morbid obesity.

The quarterly Minimum Data Set (MDS) assessment dated 2/4/15 documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition, was independent with transfers, used a cane or wheelchair for mobility, unsteady balance, and was able to stabilize without staff assistance.

The Care Area Assessment for nutrition dated 10/1/14 recorded the resident was admitted with morbid obesity at 553 pounds with a goal of planned weight loss to approximately 400 pounds.

The physician admission orders dated 5/20/14 directed staff to weigh the resident weekly four weeks and then every two weeks, notify the physician of a weight loss or gain of 3 pounds in a week or weight loss/gain if 5 pounds in 2 weeks.

The clinical record revealed the following weights on:
5/21/14 - 554.20 pounds
6/4/14 - 555 pounds

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6/12/14 - 563 pounds, a gain of 8 pounds.
The clinical record lacked evidence staff notified the physician of the resident ' s weight gain.

The clinical record lacked evidence of bi-monthly weights on 6/25/14, 7/9/14, 7/23/14, 8/6/14, 8/20/14 or the resident ' s refusal of weight monitoring.
The clinical record lacked evidence the physician was notified or the resident ' s refusal of weights.

Next recorded weight on 8/27/14 - 574 pounds, a gain of 11 pounds since last recorded weight.
Weight on 9/1/14 - 548.90 pounds, a loss of 35.1 pounds.
The clinical record lacked evidence staff notified the physician of the resident ' s weight loss.

A physician order sheet dated 9/9/14 recorded the physician order for weights every 2 weeks and notify the physician of a 5 pound gain or loss.

The clinical record revealed the resident ' s weight on:
9/11/14 - 546.60 pounds
9/24/14 - 546 pounds
10/9/14 - 539.60 pounds, a loss of 6.4 pounds.

The clinical record lacked evidence staff notified the physician of the resident ' s weight loss.

The clinical record revealed the resident ' s weight on:
10/14/14 - 538.40 pounds
10/21/14 - 538.20 pounds
10/28/14 - 541.10 pounds
10/29/14 - 541.10 pounds
11/4/14 - 551.00 pounds, a gain of 9.9 pounds.
The clinical record lacked evidence staff notified

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the physician of the resident ' s weight gain.

Weight on 11/19/14 - 559.20 pounds, a gain of 8 pounds.
The clinical record revealed staff notified the physician medical director of the resident ' s weight gain.

During an interview on 2/26/15 at 5:02 P.M., administrative nursing staff F, reported the resident refused weights in July, on 12/3/14, 12/10/14, and staff recorded 558 pounds in December without weighing the resident.
The clinical record lacked evidence staff notified the physician of the resident ' s refusal to weigh in July or 12/3/14.

Weight on 12/22/14 - 610.20 pounds, a gain of 51 pounds since an accurate weight of 11/19/14.
The clinical record lacked evidence staff notified the physician of the resident ' s weight gain.

Review of the physician ' s order sheet dated 7/1/14 documented physician II was the admitting physician and ordered the medications and treatments. This physician ' s order sheet recorded on 7/8/14, physician JJ performed the 30-day evaluation and signed the physician order sheet.

The clinical record lacked evidence of documentation of the change in resident ' s physician from physician II to physician JJ, notification of either physician, or notification of the resident of a change in physician.

Observation on 2/26/15 at 8:10 A.M. revealed the morbidly obese barefoot resident sat on the side of a bariatric bed, restlessly moved and shifted

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F 157	Continued From page 4 his/her weight. During an interview on 2/26/15 at 5:02 P.M., administrative staff F reported the resident ' s physician was hard to reach for notification, however unable to find any documentation of attempts to reach the physician. Review of the clinical record lacked evidence the staff attempted to notify the resident ' s admitting physician of weights and change of condition. The clinical record revealed on 8/21/14 the staff notified the resident ' s admitted physician once about his/her weight. Interview with administrative staff B on 2/26/15 at 5:10 P.M. reported the facility used the web based program interact for physician notification parameters and lacked a specific policy for following written physician orders and notification of the physician of a change. On 3/4/15 at 12:00 P.M., administrative staff A reported it was understood that physician II would continue to see the resident after admission and physician JJ agreed to provide care when staff were unable to reach physician II with staff recording attempts. The facility lacked a policy that directed staff on notification of physicians and following physician orders. The facility failed to follow physician orders and notify the physician of the residents weight gain.	F 157		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. Based on observation, interview, and record review the facility failed to provide resident #1 with transfers in a safe manner to prevent accidents.

Findings included:

- The facility admitted resident #1 on 5/20/14 with the diagnosis morbid obesity.

The quarterly Minimum Data Set (MDS) assessment dated 2/4/15 documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition, was independent with transfers, used a cane or wheelchair for mobility, unsteady balance, and was able to stabilize without staff assistance.

The Care Area Assessment for activities of daily living dated 10/1/14 recorded the resident became short of breath with exertion, transferred him/herself from the bed to the wheelchair with staff assistance for safety.

The comprehensive plan of care for mobility dated 11/6/14 documented because of weight,

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the residents knees hurt and legs had a difficult time holding the resident up. The resident transferred him/herself and took a few steps in his/her room with use of a cane. The resident used a wheelchair for most mobility and if he/she lost his/her balance was hard to stay on his/her feet. If the resident fell, he/she required a mechanical lift to help get back up.

The clinical record documented on 2/18/15 the resident weight of 600.4 pounds.

Review of physician telephone orders dated 2/24/15 timed 3:00 P.M. ordered transport the resident by way of secure transport to a behavioral health unit for evaluation/treatment of suicidal thought and verbal threats of harming others.

A physician telephone orders dated 2/24/15 timed 3:30 P.M. recorded to transport the resident by way of ambulance to an acute hospital for evaluation of the right foot.

Nursing note dated 2/24/15 timed 5:42 P.M. recorded the resident left the facility in the ambulance for evaluation and treatment.

Nursing note dated 2/25/15 timed 1:32 P.M. documented while trying to transfer the resident into the facility van; his/her foot was hyperextended. The resident reported pain to the touch as staff assessed the resident ' s foot with no swelling, redness, or discoloration. Staff obtained a physician order to transfer the resident to an emergency room for evaluation and treatment of the right foot.

Observation on 2/26/15 at 8:10 A.M. revealed the

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morbidly obese barefoot resident sat on the side of a bariatric bed, restlessly moved and shifted his/her weight, with no apparent bruising to either foot. During an interview, the resident reported the facility staff planned for him/her to stand on the back of the facility transport van wheelchair lift, then back that van up to the side doors of the secure transport. The resident reported telling the facility staff he/she was not able to stand that long. The resident stated the facility staff placed an office chair on the lift platform, he/she sat on the chair, and staff started raising the lift. The resident reported the lift was about a foot off the ground.

During an interview on 2/26/14 at 10:30 A.M. administrative nursing staff E reported staff pushed the resident in his/her wheelchair to the back of the facility van, assisted the resident to sit on the chair on the facility vehicle wheelchair lift, and raised the lift. The secure transport van was to pull up to the facility van with the side doors open so the facility van could back up into the open doors and the resident could step across into the secure transport van. The resident started moving around and yelled when the wheelchair flap on the lift came up and pushed against his foot, like he/she was on tiptoe.

On 2/26/15 at 11:22 A.M. administrative nursing staff D reported when the secure transport van arrived on 2/24/15, the resident stated he/she was unable to step up into the vehicle. Staff placed a black metal frame office chair without arms on the facility van wheelchair lift. The plan was the secure transport van pulled behind the facility van with open side doors; the staff would back the facility van wheelchair lift gait into the secure transport van so the resident could step

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into it from the lift gate. The resident ' s wheelchair did not fit in the facility transportation van or on the wheelchair lift. While the wheelchair lift rose with the resident seated on the chair, he/she moved and the bottom (safety) flap on the lift came up and pushed the resident ' s toes up and hyperextended the foot. Staff lowered the lift and transferred the resident with the Hoyer lift back to his/her wheelchair.

On 2/26/15 at 12:22 P.M., dietary staff BB reported on 2/24/15, he/she saw the resident seated on a blue cushion office chair on the wheelchair lift of the facility van. Staff attempted to transfer the resident from the facility van wheelchair lift to the secured transport van.

On 2/26/15 at 12:43 P.M., maintenance staff T reported during a resident transfer on 2/24/15, he/she operated the wheelchair lift to raise the resident with the facility van and then was to transfer the resident to a secure transport van. When staff got the resident in position and ready to transfer, the resident jerked back and forth. The resident rocking activated the safety wheelchair stop of the bottom of the lift. The wheelchair stop popped up and he/she hit the stop button. The resident moaned and nursing staff assessed the residents foot for injury. The resident calmed down and the lift was lowered. The resident moved around more and activated another safety switch that pulled the wheelchair lift all the way back up. The resident would not stop moving around and this caused the wheelchair lift to come up in the up position. While holding the button, maintenance staff T told the staff to disconnect the battery, which caused the wheelchair lift to stop and the main power to the lift was disconnected. " When someone

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moves around on that wheelchair lift, the very first thing was the foot thing will come up and any movement will make the lift go straight up in the up position and it will stay there. The resident moved enough to activate the safety switches. The lift would hold the resident but his/her wheelchair was too big for the lift so the resident sat on a regular chair. The entire time, the resident was moving front and back. "

During an interview on 2/26/15 at 1:30 P.M., direct care staff M reported the resident used a cane for walking short distances or a wheelchair and he/she pivots to step from one place to another putting weight on something to stabilize.

On 2/26/15 at 1:45 P.M., direct care staff N revealed in the afternoon on 2/24/15, the staff set an office chair with a u-shaped bottom on the facility van wheelchair lift for the resident to sit on. The resident leaned back and rocked on the chair to fit in the van.

On 2/26/15 at 1:50 P.M., direct care staff O reported on the afternoon of 2/24/15, the resident walked with a walker from his/her wheelchair to the van wheelchair lift to sit on a chair that sustained his/her weight. The resident ' s wheelchair was too wide for the lift and he/she was unable to step up into the secure transport vehicle. When the lift started up, the safety mechanism on the lift bent his/her toes backward. Maintenance staff T overrode the switch on the lift so the platform would go back down. Nursing staff assessed the residents foot and staff transferred the resident with the Hoyer lift back into his/her oversized wheelchair.

On 2/26/15 at 4:08 P.M., administrative staff B

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F 323	Continued From page 10 reported on 2/24/15 when the secure transport van arrived, the resident reported he/she could not step up into the vehicle. The resident walked with his/her walker from the oversized wheelchair to sit on an office chair on the facility van wheelchair lift. While ready to transfer, the resident tried to adjust him/herself on the seat, which caused the safety mechanism to operate, the wheelchair safety flap to come up on the bottom of the lift which hyperextended the residents right foot. The facility staff disabled the lift, took the residents shoe off, assessed his/her foot, placed ice on the foot, and then transferred the resident with the Hoyer lift from the office chair to his/her oversized wheelchair. The facility failed to use the facility van wheelchair lift for transfers in a safe manner to eliminate and prevent hazards of accidents for this morbidly obese resident.	F 323		